

		FOR OFF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035261</u> Facility Name: <u>Rosewood Care Center of Alton</u> Address: <u>3490 Humbert Road</u> <u>Alton</u> <u>IL</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>Madison</u> Telephone Number: <u>(618) 465-2626</u> Fax # <u>()</u> IDPA ID Number: <u>431446787001</u> Date of Initial License for Current Owners: <u>05/15/89</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Rosewood Care Center of Alton# 0035261 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>180</u>	Skilled (SNF)	<u>180</u>	<u>65,880</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,880</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>7,432</u>	<u>7,432</u>	8
9	SNF/PED					9
10	ICF	<u>4,547</u>	<u>37,776</u>		<u>42,323</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,547</u>	<u>37,776</u>	<u>7,432</u>	<u>49,755</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 75.52%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/15/89J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/15/89 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 7432Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center of Alton # 0035261 Report Period Beginning: 07/01/1999 Ending: 06/30/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	223,833	25,753	9,218	258,804		258,804	0	258,804		1
2	Food Purchase		212,813		212,813		212,813	(10,398)	202,415		2
3	Housekeeping	164,685	27,370		192,055		192,055	0	192,055		3
4	Laundry	63,722	10,028		73,750		73,750	0	73,750		4
5	Heat and Other Utilities			113,018	113,018		113,018	0	113,018		5
6	Maintenance	23,955	15,312	60,497	99,764		99,764	4,226	103,990		6
7	Other (specify): Sanitation			28,373	28,373		28,373	0	28,373		7
8	TOTAL General Services	476,195	291,276	211,106	978,577		978,577	(6,172)	972,405		8
	B. Health Care and Programs										
9	Medical Director			18,625	18,625		18,625	0	18,625		9
10	Nursing and Medical Records	1,975,910	214,121	1,688	2,191,719		2,191,719	0	2,191,719		10
10a	Therapy	52,540	1,217	421,504	475,261		475,261	(23,630)	451,631		10a
11	Activities	52,652	4,595	2,322	59,569		59,569	0	59,569		11
12	Social Services	67,030		2,214	69,244		69,244	0	69,244		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	2,148,132	219,933	446,353	2,814,418		2,814,418	(23,630)	2,790,788		16
	C. General Administration										
17	Administrative			780,881	780,881		780,881	(664,373)	116,508		17
18	Directors Fees							0			18
19	Professional Services			5,133	5,133		5,133	75,244	80,377		19
20	Dues, Fees, Subscriptions & Promotions			29,069	29,069		29,069	(12,021)	17,048		20
21	Clerical & General Office Expense	127,940	31,159	26,262	185,361		185,361	232,397	417,758		21
22	Employee Benefits & Payroll Taxes			409,249	409,249		409,249	29,548	438,797		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,521	1,521		1,521	(125)	1,396		24
25	Other Admin. Staff Transportation			21,255	21,255		21,255	13,320	34,575		25
26	Insurance-Prop.Liab.Malpractice			43,756	43,756		43,756	4,866	48,622		26
27	Other (specify):*							0			27
28	TOTAL General Administration	127,940	31,159	1,317,126	1,476,225		1,476,225	(321,144)	1,155,081		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,752,267	542,368	1,974,585	5,269,220		5,269,220	(350,946)	4,918,274		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center of Alton # 0035261 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			7,421	7,421		7,421	286,290	293,711		30
31	Amortization of Pre-Op. & Org.							20,222	20,222		31
32	Interest			283	283		283	568,532	568,815		32
33	Real Estate Taxes			97,606	97,606		97,606	0	97,606		33
34	Rent-Facility & Grounds			1,306,763	1,306,763		1,306,763	(1,293,287)	13,476		34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			1,412,073	1,412,073		1,412,073	(418,243)	993,830		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		75,667	24,665	100,332		100,332	0	100,332		39
40	Barber and Beauty Shops			19,989	19,989		19,989	0	19,989		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			98,820	98,820		98,820	0	98,820		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		75,667	143,474	219,141		219,141		219,141		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,752,267	618,035	3,530,132	6,900,434	0	6,900,434	(769,189)	6,131,245		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center of Alton**

0035261

Report Period Beginning: **07/01/1999**

Ending: **6/30/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(9,598)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(800)	2		13
14	Non-Care Related Interest	(283)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(125)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,355)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,666)	20		28
29	Other-Attach Schedule <u>Marketing Salary</u>	(54,477)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,304)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(691,885)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (691,885)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (769,189)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Rosewood Care Center of Alton

0035261

Report Period Beginning:

07/01/1999

Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services												
1 Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2 Food Purchase	(10,398)	0	0	0	0	0	0	0	0	0	0	(10,398) 2
3 Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4 Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5 Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6 Maintenance	0	0	4,226	0	0	0	0	0	0	0	0	4,226 6
7 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8 TOTAL General Services	(10,398)	0	4,226	0	0	0	0	0	0	0	0	(6,172) 8
B. Health Care and Programs												
9 Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10 Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a Therapy	0	(23,630)	0	0	0	0	0	0	0	0	0	(23,630) 10a
11 Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12 Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13 Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14 Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16 TOTAL Health Care and Program	0	(23,630)	0	0	0	0	0	0	0	0	0	(23,630) 16
C. General Administration												
17 Administrative	0	(750,881)	86,508	0	0	0	0	0	0	0	0	(664,373) 17
18 Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19 Professional Services	0	6,917	68,327	0	0	0	0	0	0	0	0	75,244 19
20 Fees, Subscriptions & Promotions	(12,021)	0	0	0	0	0	0	0	0	0	0	(12,021) 20
21 Clerical & General Office Expenses	(54,477)	135	286,739	0	0	0	0	0	0	0	0	232,397 21
22 Employee Benefits & Payroll Taxes	0	435	29,113	0	0	0	0	0	0	0	0	29,548 22
23 Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24 Travel and Seminar	(125)	0	0	0	0	0	0	0	0	0	0	(125) 24
25 Other Admin. Staff Transportation	0	0	13,320	0	0	0	0	0	0	0	0	13,320 25
26 Insurance-Prop.Liab.Malpractice	0	0	4,866	0	0	0	0	0	0	0	0	4,866 26
27 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28 TOTAL General Administration	(66,623)	(743,394)	488,873	0	0	0	0	0	0	0	0	(321,144) 28
TOTAL Operating Expense												
29 (sum of lines 8,16 & 28)	(77,021)	(767,024)	493,099	0	0	0	0	0	0	0	0	(350,946) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb Rosewood Care Center of Alton# 0035261

Report Period Beginning:

07/01/1999 Ending:

06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

mary	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	(to Sch V, col.7)
30	Depreciation	0	260,870	25,420	0	0	0	0	0	0	0	0	286,290	30
31	Amortization of Pre-Op. & Org.	0	20,222	0	0	0	0	0	0	0	0	0	20,222	31
32	Interest	(283)	568,815	0	0	0	0	0	0	0	0	0	568,532	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	#####	13,476	0	0	0	0	0	0	0	0	(1,293,287)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(283)	(456,856)	38,896	0	0	0	0	0	0	0	0	(418,243)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(77,304)	#####	531,995	0	0	0	0	0	0	0	0	(769,189)	45

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 86,508	\$ 86,508 15
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	286,739	286,739 16
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	29,113	29,113 17
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,320	13,320 18
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	25,420	25,420 19
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,476	13,476 20
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	68,327	68,327 21
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	4,866	4,866 22
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	4,226	4,226 23
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 531,995	\$ * 531,995 39

Sum_6A

86508
286739
29113
13320
25420
13476
68327
4866
4226

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number Rosewood Care Center of Alton # 0035261 Report Period Beginn 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number Rosewood Care Center of Alton # 0035261 Report Period Beginn 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	422,119	4	8.48%	Salary	\$ 47,690	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	160,040	4	8.48%	Salary	11,230	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,920		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Rosewood Care Center of Alton# 0035261 Report Period Beginning: 07/01/1999Ending: 5/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	17	\$ 341,083	\$ 341,083	5,369,465	\$ 28,920	1
2	21	Salaries - Other	Total Cost	17	2,916,125	2,916,125	5,369,465	247,253	2
3	22	Payroll Taxes	Total Cost	17	221,266		5,369,465	18,761	3
4	22	Employee Benefits	Total Cost	17	87,376		5,369,465	7,408	4
5	25	Travel	Total Cost	17	123,502		5,369,465	10,472	5
6	30	Depreciation	Total Cost	17	273,812		5,369,465	23,216	6
7	34	Building Rent	Total Cost	17	158,940		5,369,465	13,476	7
8	19	Professional Services	Total Cost	17	805,860		5,369,465	68,327	8
9	21	Telephone	Total Cost	17	167,133		5,369,465	14,171	9
10	26	Insurance	Total Cost	17	57,385		5,369,465	4,866	10
11	21	Taxes & Licenses	Total Cost	17	7,008		5,369,465	594	11
12	21	Office Supplies	Total Cost	17	291,559		5,369,465	24,721	12
13	6	Maintenance	Total Cost	17	46,996		5,369,465	3,985	13
14	17	Direct - Admin Salaries	Direct Cost	1	57,588	57,588	1	57,588	14
15	17	Direct - Admin Salaries	Direct Cost	16	910,965	910,965	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	2,944		1	2,944	16
17	22	Direct - Payroll Taxes	Direct Cost	16	95,233		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	2,204		1	2,204	18
19	30	Direct - Depreciation	Direct Cost	16	30,306		0	0	19
20	25	Direct - Travel	Direct Cost	1	2,848		1	2,848	20
21	25	Direct - Travel	Direct Cost	16	230,951		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	241		1	241	22
23	6	Direct - Maintenance	Direct Cost	16	8,188		0	0	23
24									24
25	TOTALS				\$ 6,839,513	\$ 4,225,761		\$ 531,995	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bond		X	Refinance Mortgage	Varies	10/21/93	\$ 5,500,000	\$ 0	11/01/13	7.25%	\$ 74,028	1	
2	Mercantile Bank		X	Mortgage - 60 Bed Addition	Varies	01/20/97	3,086,000	2,898,306	11/30/00	Prime+1/4	262,967	2	
3	Bank of America		X	Refinance Mortgage	\$35,233.00	10/26/99	4,027,366	4,005,399	11/2009	8.89%	259,895	3	
4	Less: Related Party Interest Income Offset										(28,075)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$35,233.00		\$ 12,613,366	\$ 6,903,705			\$ 568,815	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 12,613,366	\$ 6,903,705			\$ 568,815	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number **Rosewood Care Center of Alton**# **0035261** Report Period Beginning: **07/01/1999** Ending: **06/30/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	124,650	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	48,656	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(75,994)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	173,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	97,606	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999
	90,478	95,606	74,880	97,312	97,506
	8	9	10	11	12

1998 Payment \$48,656

FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATIC \$ 16

Accrual = 1999 Tax Bill (97,506) + 1/2 of Estimated 2000 Tax Bill (49,666) + 1/2 of 1999 Assessment for New Addition (26,428)

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 268,645 2. Number of Years Over Which it is Being Amortized: Bond Related Over Life of Bonds
3. Current Period Amortization: 20,222 4. Dates Incurred: _____

Nature of Costs: Orig. Org. Cost-\$800; Bond Trustee Fee-\$2,222; Bond Loan Cost-\$241,750; Add'l Loan Fee-\$23,145; Audit Org Cost-\$1,060
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	58,679	1988	\$ 278,953	1
2	60 Bed Addition	19,479	1988	25,461	2
3	TOTALS	78,158		\$ 304,414	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Rosewood Care Center of Alton

0035261

Report Period Beginning:

07/01/1995

Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	\$ 3,401,372	\$	10-25	\$ 145,309	\$ 145,309	\$ 1,746,026	4
5	60			1997	2,341,080		25	93,643	93,643	187,286	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Heating and A/C Modification			1990	2,786		20	139	139	1,448	9
10	Lawn Sprinkler			1992	14,401		25	576	576	4,464	10
11	General Site Work			1992	27,500		25	1,100	1,100	8,525	11
12	Fence			1990	3,627		25	145	145	1,305	12
13	Walk-In Cooler			1989	5,438		10			5,438	13
14	Sinks			1989	3,528		10			3,528	14
15	Exhaust Hood			1989	4,609		10			4,609	15
16	Fire System			1989	1,198		10			1,198	16
17	Sign			1989	5,178		10			5,178	17
18	Telephone System			1989	7,836		10			7,836	18
19	Cubicle Curtain Track			1989	8,673		10			8,673	19
20	10 Base Board Heaters			1989	2,106		10			2,106	20
21	Heat Pump			1990	2,786		10	140	140	2,651	21
22	Service Door			1991	3,150		10	315	315	2,730	22
23	Generator			1989	14,857		10			14,857	23
24	Carpet			1989	9,170		10			9,170	24
25											
26	Leasehold Improvements - Facility:										
27	Painting			1994	2,058	294	7	294		1,719	27
28	Tiling/Painting			1995	2,044	292	7	292		1,524	28
29	Nurse Station Improvements			1995	1,868	267	7	267		1,224	29
30	Painting			1995	475	68	7	68		312	30
31	Carpeting			1996	14,400	2,057	7	2,057		9,085	31
32	Base Stripping			1996	1,096	157	7	157		667	32
33	Wallpapering			1996	2,696	385	7	385		1,636	33
34											
35	Continued on Following Page										
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 3,520		\$ 244,887	\$ 241,367	\$ 2,033,195	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Rosewood Care Center of Alton

0035261

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Carpeting			1996	636	91	7	91		349	9
10	Wallcovering			1996	9,813	1,402	7	1,402		5,258	10
11	Painting			1996	2,700	386	7	386		1,443	11
12	Draperies			1997	5,190	741	7	741		2,038	12
13	Painting			1997	4,892	699	7	699		1,827	13
14	Wallpaper			1998	1,329	190	7	190		443	14
15	Tech Electronics			1998	2,735	391	7	391		782	15
16											16
17	Leasehold Improvements - Management Company:										
18	Office Construction/Improvements			1995	649		5	130	130	649	18
19	Office Design			1995	59		5	13	13	59	19
20	Office Shelving			1996	138		4	33	33	138	20
21	Office Expansion			1996	613		4	153	153	613	21
22	Office Expansion			1997	1,640		3	521	521	1,640	22
23	Office Expansion			1998	927		3	310	310	549	23
24	Office Addition			1999	457		3	152	152	152	24
25	Door Locks			1999	228		3	44	44	44	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 3,900		\$ 5,256	\$ 1,356	\$ 15,984	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0035261

Report Period Beginning:

Page 12B

07/01/1995 Ending: 06/30/2000

Facility Name & ID Number Rosewood Care Center of Alton

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Rosewood Care Center of Alton# 0035261Report Period Beginning: 07/01/1999 Ending: 06/30/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 499,216	\$	\$ 32,167	\$ 32,167	5-7 Yrs	\$ 156,828	37
38	Current Year Purchases	13,112		1,182	1,182	5-7 Yrs	1,182	38
39	Fully Depreciated Assets	336,695					336,695	39
40								40
41	TOTALS	\$ 849,023	\$	\$ 33,349	\$ 33,349		\$ 494,705	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	\$ 59,693	\$	\$ 10,219	\$ 10,219	5 Yrs	\$ 23,806	42
43										43
44										44
45										45
46	TOTALS			\$ 59,693	\$	\$ 10,219	\$ 10,219		\$ 23,806	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 7,420	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 293,711	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 286,291	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,567,690	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center of Alton

#

0035261

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☐ NO2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AID IN OTHER FACILITY

☐If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**B. EXPENSES****ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Rosewood Care Center of Alton# 0035261 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	14,458	\$ 136,368	\$	14,458	\$ 136,368	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,811	20,873		1,811	20,873	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		21,198	240,633	1,217	21,198	241,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				75,667		75,667	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Specialty Beds, Other (specify): Lab, & X-Ray	39-8				24,665			24,665	13
14	TOTAL			\$	37,467	\$ 422,539	\$ 76,884	37,467	\$ 499,423	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Rosewood Care Center of Alton

STATE OF ILLINOIS

Page 17

XV. BALANCE SHEET - Unrestricted Operating Fund.

0035261

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

As of 06/30/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 429,289	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,000)	832,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,512		6
7	Other Prepaid Expenses	11,583		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Income Tax Benefit	20,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,311,992	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	51,932		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(28,307)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,625	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,335,617	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 264,321	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,980		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,313		31
32	Accrued Real Estate Taxes(Sch.IX-B)	173,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	45,000		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	258,705		36
37	Accrued Rent	116,276		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,107,195	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,107,195	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 228,422	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,335,617	\$	48

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*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 217,708	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 217,708	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	173,514	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(162,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,714	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 228,422	24 *

* This must agree with page 17, line 47.

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